STATE OF MAINE

BOARD OF PHARMACY

APPLICATION FOR REGISTRATION

- **OUT OF STATE MAIL ORDER PHARMACY**
- **CONTACT LENS SUPPLIER**

Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8620
TTY/HEARING IMPAIRED (207) 624-8563
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: kelly.l.mclaughlin@maine.gov

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APPLICANTS FOR REGISTRATION MUST SUBMIT THE FOLLOWING:

- Completed application and $200 non refundable registration fee. Make all checks payable to Treasurer, State of Maine;
- Copy of list of officers to include names, titles, addresses, and telephone numbers;
- Copy of the last inspection report from the state licensing in which the registrant is located; and
- Verification of licensure from every state in which the licensee currently holds or has ever held.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if the application is incomplete, supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
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FAX: (207) 624-8637 - TTY/ Hearing Impaired: (207) 624-8563

John Elias Baldacci
GOVERNOR

Anne L. Head
DIRECTOR

APPLICATION FOR REGISTRATION

TYPE OF REGISTRATION (*check one*) $ 200 PAYABLE TO: TREASURER, STATE OF MAINE

- ❑ MAIL ORDER PRESCRIPTION PHARMACY
- ❑ MAIL ORDER CONTACT LENS SUPPLIER

PLEASE CHECK ONE:

- ❑ INITIAL APPLICATION
- ❑ CHANGE OF OWNERSHIP/LOCATION Current registration #:_____

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Please print or type:

NAME OF BUSINESS:_____

PHYSICAL LOCATION:_____
STREET

_____
CITY STATE ZIP CODE

NOTE: ALL CORRESPONDANCE WILL BE SENT TO THE PHYSICAL LOCATION.

CONTACT
ADDRESS:_____

_____
CITY STATE ZIP CODE

TELEPHONE #: _____FEDERAL TAX I.D. #:_____

EMAIL
ADDRESS:_____

CURRENT STATE LICENSE #:_____EXPIRATION DATE:_____
(in the state you are currently operating)

DEA #:_____ EXPIRATION DATE:_____

WORLD WIDE WEB ADDRESS/UNIFORM RESOURCE LOCATORS (URL):

_____

TOLL FREE CUSTOMER ACCESS TELEPHONE NUMBER:
_____

This section to be completed for
MAIL ORDER PRESCRIPTION PHARMACY ONLY:

PHARMACIST RESPONSIBLEFOR LICENSURE NAME:

_____
FIRST MIDDLE LAST
CONTACTADDRESS:

_____

_____
CITY STATE ZIP CODE

EMAIL ADDRESS:
_____

PHARMACIST LICENSE #:_____STATE:_____EXPIRATION DATE:_____

CONTACT TELEPHONE #:_____

This section to be completed for
FOR MAIL ORDER CONTACT LENSE SUPPLIER ONLY:

PERSON RESPONSIBLE FOR LICENSURE NAME:

_____

CONTACT
ADDRESS:_____

_____
CITY STATE ZIP CODE

EMAIL ADDRESS:
_____

TYPE OF LICENSE & LICENSE #:_____STATE:_____EXP DATE:_____

CONTACT TELEPHONE #:_____

This section to be completed
TO BE COMPLETED BY ALL APPLICANTS:

PLEASE LIST ALL TRADE OR BUSINESS NAMES USED BY REGISTRANT:

A._____
_

B._____
_

C._____

OWNERSHIP STATUS must include list of officers with names, titles, addresses, and telephone numbers

A. IF INDIVIDUAL, STATE NAME:

_____

B. IF PARTNERSHIP, STATE FIRM NAME: (A list of all partners including name, title, address, and telephone numbers must be provided)

_____

NAMES OF PARTNERS:
_____

C. IF CORPORATION, STATE NAME:

_____

NAMES OF OFFICERS: A list of officers including name, title, address, and telephone numbers must be provided.

_____
NOTE: Attach a separate sheet of paper (8 1/2” x 11”) paper if additional space is needed

LIST BELOW EVERY STATE IN WHICH THIS ENTITY HAS EVER HELD OR CURRENTLY HOLDS A LICENSE:

STATE, TERRITORY, COUNTRY	LIC/REG NUMBER	DATE ISSUED	EXPIRATION DATE

ATTACH A SEPARATE SHEET OF PAPER (81/2" X 11) IF ADDITIONAL SPACE IS NEEDED

** You must also send the enclosed **Verification of Licensure** form to any other state board where you hold or have held a license. Please follow directions on the form.

Check appropriate response to the questions below. Any **YES** response must be fully explained by written statement on a separate sheet of paper (81/2" X 11"), signed and dated, and submitted with your application.

Has any jurisdiction taken disciplinary action against your professional license/registration or denied your application for licensure? ❑Yes ❑No

Have you or any corporate officers ever been convicted of a crime other than a minor traffic violation? ❑Yes ❑No

Has this entity ever been denied registration by the u.s. drug enforcement administration (DEA) or has it's DEA registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to dispense controlled substances? ❑Yes ❑No

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

By submitting this application I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

_____
PRINT NAME

_____ _____
SIGNATURE OF APPLICANT **DATE**

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary.)

Applicant
Name:_____

Address:_____

_____
(state) *(zip code)*

License #:_____ Date Issued:_____

I hereby authorize the Board of Pharmacy of the State of _____
to furnish to the Maine State Board of Pharmacy the information requested below.

Applicant Signature: Date:

To be completed by the State Licensing Board verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named was issued:
License # Date issued Date of expiration

_____

Current Status of License: (check all that apply) ❑Active ❑Inactive ❑Lapsed
❑Probation ❑Restricted ❑Suspended ❑Revoked

Disciplinary Action: (If yes, please attach a copy of the decision and a detailed explanation for the discipline and a copy of the consent agreement(s) or decision & order(s) issued)

Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation? ❑Yes ❑No

Date of last inspection: _____

Has any inspection of the applicant resulted in deficiency ratings? ❑Yes ❑No

Signature:_____

Title:_____

State completing this form: _____

Date: _____

(SEAL)

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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard** _____
Card number

Expiration date: _____/_____/_____ **in the amount of: $**_____

Signature: _____ **Date:** _____/_____/_____